Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Mullaghmeen Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	17 September 2025
Centre ID:	OSV-0005479
Fieldwork ID:	MON-0047879

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre is a detached bungalow in close proximity to the nearest small town which can accommodate up to three adult (male and female) residents, each with their own room, and with suitable communal and private areas. The provider describes the service as supporting individuals with modern to severe intellectual disabilities and additional specific support needs in relation to physical disability, behaviours of concern, autism and mental healthcare needs. The centre is staffed 24 hours a day, with sleepover staff at night. The staff team comprises social care workers and support staff. The residents are supported to access local amenities including leisure facilities, shops, bars and restaurants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 September 2025	11:15hrs to 16:30hrs	Julie Pryce	Lead
Friday 26 September 2025	10:30hrs to 14:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted as a follow up inspection to a risk based inspection conducted on 1 July 2025. The July inspection was undertaken in response to information received in the form of notifications submitted to the Office of the Chief Inspector. This information referred to allegations of abuse which had not been reported to the provider at the time of the alleged incidents.

The inspection in July found that there had been a rapid response by the provider to ensure the safeguarding of all residents, and a detailed quality improvement plan (QIP) was presented to the inspector which outlined the actions the provider intended to take to ensure the on-going safeguarding of residents. This inspection was conducted to assess on-going compliance with the regulations with a specific focus on the actions taken by the provider in response to the findings of the previous inspection, and the implementation of the QIP.

The inspector met both residents during the course of the inspection. One resident was observed to be very relaxed and comfortable. The staff introduced the inspector, and the resident greeted the inspector and repeated their name, in their own way. Staff explained that the resident was very settled, and described the ways in which the resident would communicate if they weren't content, or if they had any request.

Later the inspector was having a chat with a staff member when the resident came and joined in. They made a request, and staff knew immediately that they were looking for a cup of tea and cake, which they then clearly enjoyed.

The inspector met the other resident on the second day of the inspection. The resident was relaxing in the living room, waiting for their lift to go to an activity. They spoke about their activity, which was bingo, and said that they could win presents. The person in charge mentioned that they could have their 'office time' when they got back, and this was clearly something the resident was pleased about.

The person in charge explained that this 'office time' had started with one-to-one conversations with each resident, using social stories to talk about staying safe, and had expanded into regular chats, often with a snack, and that the resident would spend time with the person in charge, sometimes doing drawings, sometimes just having a chat.

The person in charge documented these conversations, and was using the information to inform the assessments and personal plans for both residents, as further discussed under regulation 5 of this report.

The inspector was satisfied that all the findings of the previous inspection had been addressed, and that significant improvements had been made to all aspects of care and support in the designated centre, with only minor improvements still required in

the oversight of information in staff files. It was evident that residents were safeguarded, and that there had been improvements in outcomes for them.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective, and improvements in the daily supervision of staff had been made.

There was an appropriately qualified and experienced person in charge who was knowledgeable about the care and support needs of residents, and who had made significant improvements in the care and support offered to residents.

There was a consistent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, and who facilitated the choices and preferences of residents. Since the previous inspection, staff had raised any concerns in accordance with best practice.

There had been a robust management response to the previous allegations of abuse, and multiple strategies had been put in place to ensure the immediate and on-going safety of residents. All of the issues in the previous inspection had been addressed, and the actions agreed with the provider in their quality assurance plan were all complete or within their timeframes.

Regulation 15: Staffing

Following the allegations of abuse the provider had increased the staffing numbers so that there were always at least two staff members on duty, and this level of staffing had been maintained. In addition the person in charge (PIC) had planned rosters for several months in advance, so that if any relief staff were needed she could be assured that they were known to the residents.

At the previous inspection the inspectors reviewed a sample of staff files, and found that while there was information in the staff files as required by the regulations, the garda vetting for one staff member was out of date, there were gaps in the employment history in one of the files, and the photographic identification in another was out of date.

On this occasion the inspector reviewed all the files for the permanent staff team, and found that while the gaps had been rectified in those files previously identified by the inspector, a review of all files had not taken place, and gaps in the employment history of another staff member were found.

Where agency staff might be required, there was a memorandum of understanding between the provider and the agency, so that the provider could be assured that all the documentation required under Schedule 2 of the regulations was in place.

The provider had outlined in their quality improvement plan their intention to add a registered nurse to the staff team. This action had been implemented, and the staff nurse was on duty on the day of this unannounced inspection. The nurse was knowledgeable about the support needs of resident, including both their health and social care needs, and was involved in the review and quality improvement of some of the documentation, and in supporting the staff team to make improvements.

The inspectors spoke to two staff members and the person in charge, and again found them all to be knowledgeable about the support needs of residents, and about their role in ensuring the safeguarding of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors had found on the previous inspection that all staff training was up-to-date, and that the content for the safeguarding training was appropriate, but that staff had not adhered to the learning in that training. On this occasion, not only had refresher training been provided to staff, but a staff member had reported a concern immediately that it had arisen.

Additional training had been provided by the physiotherapist in relation to manual handling, and had arranged for the physiotherapist to do spot checks in the centre to ensure the correct use of any equipment.

Training in relation to the culture of quality and safety had been planned in accordance with the provider's QIP, and the content of this training was submitted following the inspection and appeared to be comprehensive and relevant to the support needs of residents.

Supervision conversations with staff were now all up-to-date, and each staff member had been in receipt of a monthly supervision conversation, again in accordance with the provider's QIP. A new member of staff was undergoing an induction process, and record were maintained of the progress of this staff member through the induction process.

The inspector reviewed the records of one of the recent supervision conversations for each of the four established team members, and found a detailed conversation

had taken place, with an emphasis on safeguarding, and the opportunity for staff to raise any concerns.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors had found on the previous inspection that the response of the provider to allegations of abuse had been immediate and robust. The provider presented a detailed quality improvement plan (QIP) which outlined the actions they intended to take to ensure the on-going safety of residents.

The inspector found that all of these actions had been implemented, or were progressing appropriately, and that the findings of the last inspection had also been addressed. For example, the following actions, as included in the previous inspection report, had all been implemented:

- interim safeguarding plans had been developed and submitted to the national safeguarding team
- a full review of the mix of the current staff team had been undertaken
- monthly staff supervisions had been implemented
- monthly supervision and support for the PIC was introduced
- updates and refresher training was undertaken or planned for all staff
- easy read information on human rights had been provided to residents
- all staff had current Garda vetting
- one-to-one meetings had been held with all staff in relation to the importance of immediate reporting of concerns
- a safeguarding culture survey had been undertaken, and training on the importance of a positive safety culture was planned.

The provider had established a safeguarding oversight group to meet weekly to progress the items in the quality improvement plan. The inspector reviewed the minutes of the last eight meetings of this group, and found that the QIP was reviewed on each occasion, and that progress and improvements were clearly recorded.

The findings of the previous inspection in relation to a lack of daily supervision of staff had been addressed. The inspector reviewed the records of the PIC's schedule and found that the PIC was now present in the designated centre on a daily basis, and no longer based in the organisation's central office. It was also evident from the records of the daily conversations between the PIC and each resident that there was a regular management presence in the centre.

Significant improvements had been made in all areas of care and support since the previous inspection, with an emphasis on the safeguarding of residents.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, reviews of personal plans had been undertaken, and improvements had been made.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them. Additional ways of consulting with residents and discussing safeguarding issues had been introduced.

Fire safety and risk management strategies had been found compliant on the previous inspection, and were not reviewed on this occasion.

Improvements had been made in the management of medications, and there was clear guidance for staff in the administration of medications for each resident.

Significant work had been undertaken to ensure the on-going safeguarding of residents, and in communicating with them about any concerns they might have.

The rights of residents were being upheld and supported, and residents were supported to have a comfortable and meaningful life in the designated centre.

Regulation 12: Personal possessions

The previous inspection had found that management of residents' personal money was not always person centred or supporting residents to retain control of their own finances.

The provider had begun to address this issue with residents, but it was agreed with the inspector that the timeframe for making any changes should take into account the mental health needs of residents, and be person centred. The provider was within the agreed timeframe for addressing the issues, and outlined the plans to slowly broach any changes, beginning with individual assessments for each resident.

It was evident that the needs of residents were determining the timeframes for improvements in this area, and that all efforts were being made to support residents in a person centred way.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

While the previous inspection had found that staff had received training in the safe administration of medications and that the content of the training was appropriate, there had been a lack of clarity in the guidance for staff in relation to PRN (as required) medications.

This issue had been rectified, and there was now clear information for staff as to the circumstances under which they should consider administering each medication. In addition, the resident this issue related to had been under constant review by the mental health team since the previous inspection, and changes to their medication had resulted in improved outcomes for them.

The provider had, in accordance with their quality improvement plan, added a registered nurse to the staff team, as discussed under regulation 15.

The inspector reviewed the records of three occasions where PRN (as required)medication had been administered, and found clear and detailed information as to the presentation of the resident, the rationale for the decision to administer the medication, and the effect of the medication.

The inspector was satisfied that the improvements made in medication management were appropriate, and adequate to ensure the safe administration of medication in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident which were regularly reviewed and were based on a detailed assessment of need. Where the previous inspection had found that some of these reviews were not meaningful, this had been rectified and a review of all care plans had taken place.

These reviews had resulted in changes to the supports offered to residents in some cases, for example, the care plan in relation to self-regulation for one resident had been revised to ensure that visits to the resident, such as appointments with members if the multi-disciplinary team, were only to be made in the afternoons. This protocol allowed the resident the morning time for a low arousal start to the day, and offered support to the resident in relation to self-regulation.

A stress management care plan had been devised for the other resident, and this involved the use of social stories, the management of transport to reduce anxiety around this activity, and a greater focus on structure of routines and activities. The

person in charge had identified the need for increasing the listening to the resident's communication, and to supporting choice making also that an increase in the resident's control over their environment would support the management of their anxiety.

In addition to these changes, some environmental changes had also been identifies, and these were already in place. For example the location of the kettle had been changed to reduce the level of footfall in one of the living areas so as to support the relaxation time of one resident.

The person in charge presented evidence of scheduled workshops to be delivered by the psychology department to the staff team relating to the particular support needs of residents, and the confirmation documentation included interim guidance for staff pending this training.

Overall there had been significant improvements in care planning in a relatively short timeframe, and the person in charge had introduced an oversight document for each care plan which would support the monitoring and oversight of care plans to ensure continuing quality improvement.

Judgment: Compliant

Regulation 8: Protection

One of the major concerns of the previous inspection was the failure of staff to report any concerns in a timely manner. This issue had been addressed in various ways, including discussion at staff meetings, individual discussions with all staff, and additional and refresher training provided to staff as discussed under regulation 16.

Since the previous inspection a staff member had reported a concern to the management team. The report had been made on the day of the concern, as required by the provider's policy, so it was clear that staff were adhering to the policy, and had taken on board their role in the safeguarding of residents.

The inspector reviewed the safeguarding plan in place to ensure the safety of residents, and found that it had been reviewed and updated since the previous inspection, and again following an occasion where a staff member had entered the house without notice, and had escalated the behaviours of a resident associated with their anxiety. The protocol in relation to entering the house had been updated, and the PIC had ensured that all staff members, including any agency staff, were aware of this protocol.

There was detailed information relating to the support of residents, including the provision of activities, and the ways in which to communicate with residents. The information about communication was detailed and included guidance about phrases

which are to be avoided when communicating with one resident, and alternatives to be used.

As previously mentioned, the PIC had introduced regular safeguarding conversations with resident, using social stories to assist their understanding. These conversations and the frequency at which they were held, was led by the needs and the response of each resident.

In addition, the PIC had introduced a formal assessment of positive behaviours for one resident. Observations were being made of the circumstances surrounding any observations of positive behaviour, with the aim of using the findings to promote a positive environment and reproduce antecedents to positive behaviour for the resident.

The PIC discussed with the inspector a 'teams agreement' approach to staff discussions, which will involve staff discussing and agreeing values, with a focus on the rights of residents.

All of the issues found in the previous inspection, relating to the lack of supervision of staff on a daily basis, the failure of the provider to ensure that staff were appropriately garda-vetted, and the failure of staff to report concerns relating to abuse in accordance with the organisation's policy, had all been addressed in detail. It was evident that the provider had taken all the necessary steps to ensure that residents were safeguarded from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Significant improvements had been made since the previous inspection in ensuring that the rights of residents were upheld. Together with the focus on safeguarding, improvements had also been made in communicating with residents and consulting with them.

Consultation was done both individually and together, for example the two residents planned some joint activities such as take-away meals together. Residents meetings had been held, and easy-read information was available to assist residents' understanding and choice making.

Residents had been invited to join the staff team meetings, and had attended their first one the week prior to this inspection. There were various ways in which outcomes had improved for residents, and staff and the PIC explained that they were more comfortable in their home, and were using the communal areas of the home more frequently.

Residents were being supported to engage in a range of activities in accordance with their preferences, including some new activities such as massage therapy.

Overall residents were supported to have a good quality of life, and to be supported to make choices in ways which were meaningful to them.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullaghmeen Centre 4 OSV-0005479

Inspection ID: MON-0047879

Date of inspection: 26/09/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Where agency/ transient staff are required, the PIC has ensured a panel of staff (agency & relief) are available to the house and who have completed a comprehensive induction to the service including shadowing more experienced staff members. A review of all permanent staff members files will be undertaken by the HR dept and any gaps in employment history followed up with the relevent staff members. Going forward all staff recruited to the service will be required to provided comprehensive information on employment history including months and years. Any gaps in employement history will require an acceptable explanation from the candidate.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	19/12/2025